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ABSTRACT

Attention Deficit Hyperactive Disorder is a common diagnoses for school aged children. Studies have indicated that within these diagnoses children of color are disproportionately diagnosed in comparison to their white counter parts. Many have questioned whether this disproportionately comes from a lack of cultural awareness on the part of the clinician and/or a potential misdiagnosis of trauma that be being missed throughout the evaluation process.

In this study 6 licensed social workers who have worked with Latino boy in the past were interviewed. They were asked to discuss their evaluation process and what measures they take to rule out a potential trauma diagnosis. The study was able to not only explore their varying methods but also the barriers they encounter throughout their process.

Findings indicate that every participant varied in their techniques of diagnosing. While their techniques seemed to differ there was found to be commonality in the barriers they faced when diagnosing and how that impacted their work.

**ADHD OR PTSD? EXPLORING THE OVER DIAGNOSIS OF ADHD IN MINORITY
BOYS WITH THE POTENTIAL OF PTSD**

An independent project completed in
partial fulfillment of the requirements for a
Master's Degree in Social Work at Smith College.

Megan Negrón
Smith College School for Social Work
Northampton, MA 01063

2016

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I would like to first thank the amazing students, teachers, and staff that impacted my learning during my first placement. I was inspired to do this study based on my experiences with the students and all they taught me during the year. I will hold those memories with me throughout my work in the field and remember the moments that truly reminded me that I was in the right field

I also want to acknowledge the people that supported me throughout the research process. My amazing advisor Elaine Kersten for believing in my vision and helping me turn my work from a passionate interest to a study. Also, Karessa for her outreach to potential participants on my behalf and her diligence in helping me alongside constructing a thesis of her own. Lastly, Amir for leaving space for me to express frustration, sadness, and hopefulness throughout the literature review process, reminding me of the power I hold and the impact I can create in the lives that I touch.

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CHAPTER 1: INTRODUCTION

As stated by Husain, Allwood, and Bell (2008), due to the similarities between symptoms related to the childhood disorders of Attention Deficit Hyperactivity Disorder (ADHD) and Childhood Post Traumatic Stress Disorder (PTSD), there is a great possibility of misdiagnosis. In their study they explored the overlap between both ADHD and PTSD in elementary school aged children exposed to the Bosnian War. They found that “the link between PTSD and ADHD actually reflects symptoms of PTSD that mimic ADHD” (Husain, Allwood, and Bell, 2008). This similarity in common symptoms can lead to misdiagnosis, another words, diagnosing a child with ADHD when s/he actually has childhood PTSD. Misdiagnoses can lead to the wrong treatment for the child as well. Literature suggests that often elementary school children referred to school psychologists who appear to be struggling with ADHD are likely to be diagnosed with ADHD (Haile, 1999). The opposite can be said to children struggling with PTSD, much of the time these children are underdiagnosed and go unidentified (Husain, Allwood, & Bell, 2008). Currently, the literature identifies discrepancies between symptoms of PTSD and ADHD and suggests a failure to appropriately distinguish and diagnose these two conditions (Bauermeister, 2003). As noted above, with misdiagnosis comes the potential to provide incorrect treatment.

Furthermore, the literature suggests that the rate of ADHD misdiagnosis appears to be higher for elementary school minority identified boys (Morgan, 2013). In one study done by Schmitz (2003), Latino boys were diagnosed at a higher rate which Schmitz found to be an issue that the author concluded was associated -- with access as well as the family’s inability to speak English. As a result, Latino boys are at even higher risk of an ADHD misdiagnosis and subsequent incorrect treatment than the non-Latino elementary school population (Morgan, 2013). This can also be said for African American/ Black identified student who have a 9.8%

rate of ADHD diagnosis compared with White/ non-Hispanic students who are diagnosed at 8.7% rate (National Resource Center for ADHD, 2011). Though studies have found these racial discrepancies in diagnosing, many others have actually argued the opposite, stating that “ADHD diagnosis for African Americans, Hispanics, and children of other races/ethnicities were 69%, 50%, and 46% lower, respectively, than for whites” (Staff et al., 2013). Clearly, discrepancy exists in terms of knowing whether or not certain groups receive higher rates of these diagnoses. And of course, with higher rates, comes the likelihood of misdiagnosis. It appears that elementary school aged minority boys may be diagnosed with ADHD at a higher rate than their white counterparts (Bauermeister, 2003). As noted by Schmitz (2003), “Minority children are more likely than white children to be diagnosed with ADHD. In particular, ADHD-related behaviors must be understood within the context of cultural environments and expectations”. What Schmitz discusses is a potential explanation for the idea that many Latino boys possibly may be misdiagnosed due to the cultural discrepancies that exist and what parents would describe as hyperactive behaviors and what they would not.

Because of the issues related to misdiagnosis cited above, and because of the potential consequences relating to misdiagnosis, such as taking medications for the wrong diagnosis, and the discrepancies reflected in the literature, further research in this area is indicated in order to learn if there are discrepancies during evaluation protocols that guide clinicians who evaluate these children.

The purpose of the proposed study is to explore protocols used by clinicians in the field who develop a diagnosis when evaluating school aged boys who have been referred due to issues such as ADHD, or other observed classroom behavioral concerns. A qualitative study was conducted in which evaluating clinicians described their process for arriving at a diagnosis of

childhood PTSD, and then, I compared their approach with best practices reflected in the literature. Thus, a major goal of this study is to identify the extent to which best practices for differential diagnosis approaches are employed by evaluators that misdiagnosis, especially between ADHD and PTSD, in elementary school aged Latino boys.

CHAPTER II: LITERATURE REVIEW

After exploration of the literature it is evident that there are gaps not only in the process for diagnosing ADHD in correlation to PTSD but also racial discrepancies that are typically overlooked. As I further explored it became evident through the research that consistency in the diagnostic process along with accounting for issues such as time and language barriers were all areas of concern. Though these areas were discussed in the literature it appears as though there has been no solution to the issue. As the literature is examined it is apparent that there are missing pieces in this process, especially when we include race. Following is a review of several key areas that inform my area of focus. Namely, I provide a review of childhood mental issues to gain insight into commonly experienced childhood mental health issues, and in particular in terms of how it plays out in school environments. Next I review childhood Post traumatic stress disorder and Attention Deficit Hyperactive Disorder, also known as ADHD, followed by a review of how these childhood conditions are diagnosed, and consequences of this process.

Childhood Mental Health Issues

In reference to Merikangas and colleagues (2010), approximately 1 in 5 children will experience a mental health disorder severe enough to impair functioning and increase risk for a variety of deleterious academic and social outcomes. With that being said this leads us to explore where we find most children - in school. Within this setting, children interact with teachers and staff which leaves these individuals as the primary actors in identifying children with mental health disorders and referring them for treatment. “However, research indicates that many teachers lack confidence in their ability to identify and assist children experiencing mental health symptoms” (Frauenholtz, Williford, & Mendenhall, 2015). This then brings us to question the ability of these professionals to take on this responsibility of referral and participating in

evaluations, “without sufficient education and training on mental illness, school teachers are less likely to have the capacity to recognize related symptoms in students and make referrals for care” (Frauenholtz, Williford, & Mendenhall, 2015).

Teachers and staff alike are given little to no formalized training and professional development in mental illness (Frauenholtz, Williford, & Mendenhall, 2015). Therefore there is no guarantee that children being evaluated are receiving not only correct evaluations but also timely referrals. Which leads to the following concern in delaying the detection of possible diagnoses and receiving appropriate treatments leaves students at a disadvantage because many disorder trajectories depend on timing of diagnosis and intervention (Powers, Wegmann, Blackman, & Swick, 2014).

With these issues come a variety of challenges, including but not limited to limited budgets, time, physical space, and personnel resources needed to operate new services (Splett & Maras, 2011). “Additionally, there are competing priorities in schools (Short et al., 2011), such as the increased pressure to focus on academics to meet accountability demands of legislation such as the No Child Left Behind Act (2001)” (Powers, Wegmann, Blackman, & Swick, 2014).

Consequently, many teachers may lack the knowledge necessary to address children's mental health and may feel unprepared to identify and intervene with mental health issues in the classroom. In other words, some educators may have low mental health literacy and yet are being required to not only make referrals but also participate in the evaluation process (Frauenholtz, Wilford, & Mendenhall, 2015).

Attention Deficit Hyperactive Disorder

Attention Deficit Hyperactive Disorder, also known as ADHD, is defined by the DSM V as, inattention: six (or more) of the symptoms have persisted for at least six months to a degree

that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: and hyperactivity and impulsivity: six (or more) of the symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities (American Psychology Association, 2013). These symptoms include but are not limited to difficulty sustaining attention to tasks or play activities, losing items necessary to complete tasks, forgetfulness in daily activities, not following through on instruction and failing to complete assignments, and often not seeming to be listening when being spoken to.

According to the Center for Disease Control (2011), an average of 6.4 million children in the U.S. have received an ADHD diagnosis by a health care provider. Of that 6.4 million, 6.1% are medicated which when compared to the statistics from 2007, is a 28% increase. With regard to the racial breakdown, White (non-Hispanic): 4.1 million children have ADHD (8.7%) Black or African American: 904,000 children have ADHD (9.8%) Hispanic or Latino: 659,000 children have ADHD (5%) (Center for Disease Control, 2011).

Childhood post traumatic symptom disorder

In reference to the DSM V, PTSD is described as the exposure to actual or threatened death, serious injury, or sexual violence along with the presence of intrusive symptoms associated with the traumatic event(s) (American Psychology Association, 2013). This is diagnosed with one or more intrusive symptoms like: recurrent, involuntary, intrusive memories, repetitive play where themes of aspects of the traumatic event are expressed, frightening dreams without recognizable content, and reenactment in play. Followed by avoidance of external reminders. Two or more negative alterations: inability to remember details of the traumatic event, feelings of detachment and estrangement, negative beliefs or expectations of oneself, and

persistent negative emotional state. And two or more marked alteration in arousal: irritable behavior, angry outbursts, reckless or destructive behavior, hypervigilance, problems with concentration, and sleep disturbance (American Psychology Association, 2013).

Much of the areas of overlap between the diagnosis of PTSD and ADHD can be in a variety of neurocognitive factors. More specifically, cognitive functions including attention, memory, and intellectual functioning (Adam, 2015). Looking closely into the link between hyper arousal and inattentiveness. This is true across both children and adults (Cuffe, 1994).

Much of the research done with regards to PTSD has been on veterans. Though it is important to consider that any individual can experience the effects of PTSD. In a study done by Adam and colleagues (2015), he explores the overlap between PTSD and ADHD within adult veterans. He recognizes that most commonly PTSD is linked to overlap with substance use disorders and anxiety disorders and less so with ADHD. Interestingly enough, it was found that the prevalence of PTSD was more than six times higher among adults diagnosed with ADHD in comparison with those without an ADHD diagnoses (Adam, 2015). The study reported that 36% of male veterans diagnosed with PTSD likely met criteria for ADHD in childhood and 28% likely met current criteria for ADHD. Yet, as Adam (2015) describes it, the impacts of trauma are clear on neurocognitive performance.

Diagnosing ADHD and Childhood PTSD

When I looked closer into youth and analyze their experiences of both PTSD and ADHD researchers have found higher levels of re-experiencing PTSD and symptoms of hyper arousal—but not avoidance— when compared to youth with adjustment disorders (Cuffe, 1994). Again this speaks to pediatric samples indicating a consistent pattern linking ADHD inattention to PTSD hyper arousal symptoms (Adam, 2015). Similar links were also seen in Becker's work

linking ADHD and conduct disorders (2002). ADHD hyperactive or impulsive symptoms were related to total conduct disorder severity and avoidance symptoms (Becker, 2002). Research is still left to be done in reference to the nature of comorbidity of PTSD and ADHD, specifically in children (Cuffe, 1994).

In order to guide better treatment and theory application, Adam (2015) believes clarified patterns have to be found; this was in reference to his work with veterans. If we are finding gaps between the adult populations it is likely that these gaps also exist with children.

For implication purposes, exploring this connection with children is necessary in order to develop appropriate treatment models for this group that addresses the unique elements within the overlap of ADHD and PTSD (Adam, 2015). More specifically, Adam believed, treatment of neurocognitive symptoms, such as ADHD symptoms, should be included in PTSD therapy options, which ultimately may enhance both PTSD and ADHD treatment response and facilitate functional recovery.

Now looking closer into the population for this study, children ranging from 4- 17 years of age have been the targeted age groups studied. Of this age group the overwhelming majority have been of middle class Caucasian background. In the study done by Becker (2002), family trauma was explored and participant dynamics included 53% White, 35% Latino, and 6 % African American. In this study they also had mothers evaluate whether or not their children qualified for ADHD. This was not a formal diagnosis by a health care professional but rather the observations of the mother of their child's behavior. This study also solely relied on the observations of the mothers and not the fathers. All of the children had been exposed to domestic violence and with this Becker measured the chance of the child developing a conduct disorder

that overlapped with an ADHD diagnosis. A key issue with this study from my perspective was that it lacked racial diversity in its sample.

Keeping in mind the findings of Becker but acknowledging the racial disparities, article presented by Morgan (2013) was useful in acknowledging underdiagnoses of ADHD within minority groups, in comparison to their white counterparts. This could be due to a variety of factors as Bauermeister (2003) states in his work; cultural and language barrier considerations, not to mention, the lack of access to health care within minority populations. Morgan (2013) and Bauermeister (2003) both explore the risk factors within minority populations that can lead to an insufficient diagnosis and ultimately, a treatment plan for these children. Morgan (2013) goes on to explain: increased risk of being diagnosed included being a boy, being raised by a single mother, being raised in an English speaking household, and engaging in externalizing problem behaviors. There is some intersection that can be found within Latino population exposure and the risk factors of being diagnosed. First off, many Latino boys are raised in single parent, matriarchal households (Bauermeister, 2003), this in itself has two characteristics that put this group at a risk of diagnosis. Not to mention exposure to other factors such as: low birth weight, low maternal education, low household income, greater frequency of classroom problems, and lower academic achievement (Morgan, 2013). Much of the extent of disparities for Latinos in regards to ADHD diagnosis and treatment is unknown and has yet to be systematically examined in accordance to Morgan (2013).

Specific issues related to diagnosing PTSD and ADHD with Latino children in schools

When I analyzed the Latino experience whether it be immigrant or multi-generational, a variety of opportunities for PTSD to occur. In being a minority in the U.S. the challenges faced are much different than the Caucasian experience. ADHD expression of systems can be triggered

by the stress of an environment or chaotic family lives. It is my understanding from my review of trauma literature that traumatic events interrupt normal processes of attention and arousal in both adults and children (as in post-traumatic stress disorder) (Becker, 2002). It is possible that for children expressing symptoms of ADHD, extreme stressors could serve as a catalyst. As of now, little investigation has been done in reference to the family life in children with ADHD (Becker, 2002), never mind within a Latino community context (Bauermeister, 2003). Preliminary evidence suggests that exposure to family conflict at an early age gives rise to ADHD in children, especially those who are more frequently exposed (Glod, 1996).

Based on the research it is evident that there is a lack of exploration into minority children and the possibility of misdiagnosing children with ADHD. The following research will explore the possibility of Latino children having a PTSD diagnosis rather than and ADHD diagnosis. Though it has not been found that ADHD is over diagnosed in Latino children; it is still likely that much of the diagnosis that have been made could have been mistaken for ADHD, without consideration of PTSD as a possibility. This will be important in order to make sure that Latino children are not only receiving appropriate clinical treatment but also medication to manage their symptoms.

Best Practices when diagnosing PTSD and ADHD in Latino and non-white school aged children

Behavior rating scales have been used to evaluate a potential ADHD diagnosis. These scales are completed by “parents, teachers or the patient themselves, depending on which scale is chosen, and are considered to be an essential part of the full assessment process for ADHD” (www.cdc.gov). Along with the rating scales comes a clinical assessment constructed from the DSM, this involves “the comprehensive evaluation of information gathered from a number of

sources, including: clinical examination; clinical interviews; assessment of familial and educational needs; and assessment tools and rating scales” (www.cdc.gov).

However, there is concern related to the use of behavior rating scales, specifically with elementary students of color. As Flower and McDougle found, “because African American boys and girls are twice as likely to be identified with ADHD behaviors by some of these instruments. The majority of ADHD-specific behavior rating scales have face validity based on the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) diagnostic criteria”. With that being said they were also able to explore how those who have developed these tools of measurement “have failed to use national samples with significant numbers of ethnic minorities to ascertain that screening questions are in fact detecting equivalent behavioral abnormalities across cultures” (2010). Instead, Flowers and McDougle offer the initiative of using Terry and Vanderbilt Attention-Deficit/Hyperactivity Disorder scales for diagnosing ADHD in children of color. Yet they are aware that more needs to be done in exploring these scales and correctly diagnosing ADHD specific behaviors (2010).

Summary

The need for further study as reflected in the above due to the lack of exploration in the impact that trauma has had on this population and rush to diagnose and move these children along. This study attempted to expand our understanding of these issues by talking to professionals about their protocols and how they avoid misdiagnosis in their practice.

CHAPTER III: METHODOLOGY

The purpose of this study was to investigate clinician's methods to evaluating Latino, elementary school- aged boys for ADHD while addressing the possibility of a PTSD diagnosis. I examined evaluation procedure, barriers to completing full evaluations, and how clinicians safe guard against misdiagnosis. Specifically, I offered a guide for the interview, but asked subjects to describe the referral process, and ask them to include how they go about evaluating these children, and what barriers they may encounter and any particular issues with cultural differences, and how they address these.

The study also investigated the gaps in these evaluations, gaps due to cultural experience, cultural interpretation of mental health, and language barriers. Clinicians were asked how they are able to make a diagnosis while addressing the variety of cultural experiences that the client may have. The population that was examined was Latino, elementary school- aged boys. The data was collected from clinicians who have worked with Latino, elementary school aged boys and are licensed in the field. The study was a quantitative, interview based study in which I conducted face to face interviews with 12 subjects to gather a narrative.

Sample

Recruitment consisted of snowball sampling to obtain participants. Specifically, I was able to reach out to those I knew working in the field via email and phone and explain my study. From this they were able to refer me to other clinicians that may be willing to participate. Inclusion criteria for participation included: clinicians who were licensed in their field as LCSW, LMFT, or LPC and participants had to of had experience working with Latino, elementary school- aged boys. There were 12 participants in total.

I recruited clinicians from a variety of backgrounds in reference to race, gender, ethnicity, class, age, and years in the field. Initial contact consisted of an explanation of the inclusion credentials and reassurance that participation would not impact licensure.

Ethics and Safeguards

Interview locations were negotiated with each participant. In order to assure privacy, interviews were arranged in mutually agreed upon locations which ensured privacy, either in their office or in another location that met privacy needs. Phone interviews were done if the participant was unable to meet in person or were living out of the area. All interviews were audio recorded and notes were also taken with the consent of the participant. I then transcribed each taped session and analyzed the data through initial coding and identifying themes, similarities and differences across the aggregate results. I then compared my findings with protocol steps reflected in the literature, and issues that are often embarked in these evaluations that may lead to missing PTSD and evaluating as ADHD instead. All identifying information was deleted. Coded information was stored with password protection and will remain stored for at least three years in a secured location, after which time all information will be destroyed if no longer needed by the researcher. All participants were provided with an informed consent (see Attachment C).

Participants were informed that there would be no financial compensation for their participation in the study. Although there was no financial compensation, participants were informed of the benefit of clinicians gaining knowledge that could be shared on how to conduct evaluations, and have an opportunity in this confidential dialogue to express concerns they may have in barriers to achieving all necessary steps in the protocol. Also, the social work community as a whole can re-evaluate best practices when diagnosing ADHD in minority school aged boys who have faced trauma. This could also improve servicing this population as well.

Data Collection

The Smith College School for Social Work Human Subjects Review Committee approved this study (see HSR Attachment). Participants were provided with the informed consent at the time of the face-to-face interview and in advance, if the interview was conducted over the phone. Interview questions were also sent via email before the interview. Data collection consisted of on average 45 minute interviews depending on how much the participant had to share. Eight open ended interview questions were asked regards to steps taken to diagnose ADHD and how cultural belief and influence impacts diagnosis. Demographic questions were also asked referencing: gender, race, ethnicity, location, and educational degree and number of years in the field. All interviews were audio recorded and notes were also taken with the consent of the participant. Sessions were then transcribed and analyzed through initial coding and identifying themes, similarities and differences with identifying information removed.

Data Analysis

Themes were observed and emerged through the interview guiding questions along with participant response. All data coding was done manually.

CHAPTER IV: FINDINGS

The purpose of the study was to explore protocols used by clinicians in the field who develop a diagnosis when evaluating school aged, Latino boys who have been referred due to issues such as ADHD, or other observed classroom behavioral concerns. A qualitative study was conducted exploring the evaluation process as described by clinicians. This process was then compared to the literature and also colleagues in the field whom also participated. A goal of this study was to identify best practices and view potential for misdiagnosis between ADHD and PTSD in Latino, elementary school aged boys. This chapter presents the results of the study findings. Qualitative analysis was conducted. Findings are presented following analysis, reflecting common themes that emerged across respondents to questions asked, and also include unique responses that contribute to our understanding of the issues faced by clinicians during the evaluation and diagnosis process. Special emphasis is placed on protocols used by clinicians during the evaluating and diagnosing process.

The study called for licensed clinicians who had in the past or presently are working with Latino school aged boys with a potential ADHD diagnosis. The sample came from a variety of locations ranging from the east coast to the west coast of the United States. Clinicians also varied in race and bilingual ability. All of the sample identified as female.

Participants were asked about evaluating and diagnosing protocols they use especially for Latino elementary boys, any barriers they face during these procedures. Findings reflect responses across participants, and are presented in terms of key content areas that include: 1. a general discussion about childhood trauma; 2. differentiating between PTSD symptoms and ADHD symptoms; 3. Misdiagnosis issues ; procedures used in evaluation; and results reflecting what clinicians talked about in terms of barriers to the clinical protocols they use to guide their evaluations.

Evaluation of Childhood Trauma- How Childhood Trauma is Explored and Addressed

The exploration of childhood trauma is done in a variety of ways in regards to this group of participants, including home visits. As noted by one participant:

I would usually ask to see the child in their home setting because as we all know coming in to an appointment and sitting in an office with a licensed professional is a different experience for not only the child but also the family and the best way to get a clear picture is to get a glimpse of what home can be like

Also interviews with parents and the ability to allow parents to give family accounts of their journey,

I basically ask parents to walk me through- what was it like coming here?, where was your first job?, I try to have them make it a story so I am able to truly get a picture of the history and even the trauma mom and dad might have faced that intergenerational.

Along with these methods also motivational interviewing, child information, and a series of behavioral checklists such as SNAP 4, life events checklists, and clinically administered PTSD scale were included. Also emphasis was put on the necessity of trauma informed education “so that teachers are able to assist in this process more and understand these behaviors in a lens other than ADHD”.

Differentiating Between PTSD Symptoms and ADHD Symptoms

Every participant had a different method to differentiating between these symptoms ranging from: focusing on play therapy reactions and analyzing them thoroughly, and just being mindful of daily living experiences. Some statements included: “We team up with another agency to help in the process and utilize resources that we don’t have”, “getting a good history-

the intake process is so important”, and “honestly I just avoid it all together and typically will diagnose as an adjustment disorder”.

Guarding Against Misdiagnosis

There were several ways explained as to how participants guard against misdiagnosis as much as they can. Some of the common themes include: examining for trauma, “be aware of the child’s environmental factors and systematic oppression. Violence exposure. Though symptoms resemble one another being mindful of daily living experiences can differentiate so much”. Also using psychiatric evaluation was important to one participant as it allowed her to remove the responsibility of diagnosing, “honestly I would rather rely on the psychiatrist to do their evaluation and stick with a generalized adjustment disorder diagnosis on my end to avoid misdiagnosing”. While another stated, “my agency requires me to rely on the psychiatrist- I cannot give an ADHD diagnosis on my own”.

Another participant stated what she does when she notices a misdiagnosis has occurred and how reassessing the right way is important,

Many times we have to start all over again if we see something is just not working and I would rather have the child off of their meds and completely themselves and go from there rather than attempting to evaluate behaviors being compromised by meds that have been given and may not even be working.

Last, the most common answer with 4 out of 6 participants agreeing that good communication with prescribers is key. As a participant expressed:

I need to make sure we are all on the same page. Because I have seen the outcome if we are not- kids end up on meds are worse than when they came in and we are left frustrated and

confused- the kid included. Therefore I know that good communication between everyone involved is the best way to avoid much of the troubles that come with misdiagnosing.

This communication also includes checking in with family about child's progress, "we need to monitor kids when they are on their meds and take in parent reports because the way they may be behaving on meds in school may be totally different compared to what is going on at home".

Ability to conduct diagnostic protocols with all children

While one participant stated she is able to conduct all steps in the diagnostic process, this was not the case for the other 5 participants. For instance, someone stated- "well it really depends on the kid. Depending on the kid and their crises and their family then that decides on if I have the ability to get through a thorough evaluation". Others discussed the pressures from their agency to give a diagnosis in a window of time in order to bill insurances as needed which leaves clinicians with little time to explore further into the alleged idea of ADHD. A statement from a participant in regards to these pressures is as follows:

The agency needs to bill in a particular window of time and this sometimes adds a pressure and depending on how big my case load is I have to put something down to continue to move forward. But then that leaves me with having to go back and fix any errors I may have made from rushing. That's why I try to stick with a general behavioral disorder diagnosis instead of being so specific if I am unsure.

Procedures for Evaluating Latino Elementary School Aged Boys referred for ADHD or Other Behavioral Concerns

Participants stated that they were mostly referred children through teachers, depending on the agency. In some situations parents would bring in their child after a teacher/ school administration had expressed concerned in regards to the child's behavior in the classroom. "I

used an ADHD questionnaire to start off and this was given to the school social worker, teachers, and parents. I wanted at least 5 people to identify behaviors”. While others discussed their intake process, including this from one participant:

Everyone gets an intake over the phone and they are able to discuss their concerns and what issues they want to address about their child, many times we will ask if anyone referred them to our agency and if so many clinicians would tend to reach out to the referral individual for more information if needed, that’s what I do, especially with ADHD cases.

Protocol Methods for Latino Boys Specifically

Most participants stated that they do not have different ways of evaluating Latino boys in comparison to other clients while two stated that their approaches do differ with this population. One stated that she accounts for gaps in language which she is aware impacts a child/ families’ affect. Which is something to consider when going forward in evaluation:

I have to keep in mind that affect is in language and if a family is struggling to find the right words in English to express themselves or the child then I am losing something in that therapeutic process. I’m losing the affect.

Another participant stated:

Well of course I have to consider systematic racism and the everyday trauma that has on my families, I have to consider how these racial discrepancies then impact poverty and education. And for my immigrant families I have to consider the familial trauma of coming to this country and the new identities many of them are forced to form. While many of my clients’ parents don’t find these circumstances to be traumatic there is an underlying trauma in these predicaments.

Steps Taken in Working with Non- English Speaking Families

Half of the participants stated that their agencies have provided Bi- lingual documents when working with Spanish speaking families. Two of the 6 stated that they were able to call a “language line” to get a translator. With that said, out of the 3 that did not have bi lingual documentation they mentioned utilizing not only the language line but also an adult family member or even child sibling to assist in translating, one participant strictly relied on familial translation. For instance, “I don’t speak Spanish so I had to ask siblings, usually around middle school age was the youngest if I didn’t have access to a sibling that was older, to translate and communicate with me and the parents”.

Barriers to Conducting Protocols

The greatest barriers agreed upon across all 6 participants was time and the pressures to move the process along for these children as quickly as possible. These pressures coming from their agency, parents, and the schools connected to the children. Again, referring to time and the limitations I completing the process.

For non- Spanish speaking clinicians language was another barrier they encountered. As stated by one participant:

Yea it’s hard because home visits are so important but what am I or the child getting out of it if I can’t even understand the interaction happening between the family. Many times I just have an older sibling interpret what is occurring and speak for me because we struggle with even getting interpreters in the first place.

While on the opposite end Spanish speaking clinicians discussed their need and how demanding the work can get as they attempt to be an interpreter for a variety of families in the agency. As one Spanish speaking participant stated:

It is great that I am bilingual because I do not have to depend on another person to interpret for me- this makes my cases run smoother for me. But at the same time it can add stress when I am trying to get my things done and I'm having to interpret for people or people's interpreters don't show up and I have to step in.

Findings Summary

The results highlight how clinicians work in the field to address childhood trauma and use specific protocols during assessment and diagnosis. Results further indicate that clinicians are aware of misdiagnosis and do what they can to avoid this situation. Results also highlight that misdiagnosis is closely tied to the lack of consistent protocols to assure consistent results, but that for Latino boys in particular, it is not always possible to follow protocols and this can lead to misdiagnosis. The next chapter will present a discussion of these results in terms of current literature, and also highlight nuances offered in the data collection that add to our understanding of this phenomenon.

CHAPTER V: DISCUSSION/ CONCLUSION

The objective of this qualitative study was to explore the practices used by clinicians when evaluating Latino, school aged boys for ADHD and if within their techniques if they address trauma in their work. While some of the methods used by participants were reflected in the literature, it was evident that every therapist had their own way of evaluating for ADHD and effectively rule out trauma in their practice. Findings in my study identified that there was no consistent method present.

During the research process it became obvious that procedure to evaluate for ADHD in Latino, school aged boys varies from not only therapist to therapist but also from agency to agency. This chapter is going to discuss 1) key findings, comparing and contrasting previous research and the study's results; 2) implications for social work practice, discussing the importance of this work on the social work community and how social workers can apply these findings in their work; and 3) recommendations for future research in ADHD evaluation of Latino, school aged boys that identifies procedures that rule out misdiagnosis when the root issues are trauma based.

DISCUSSION OF KEY FINDINGS

In this section, I discuss my study key findings in terms of previous literature as well as new findings related to my study.

Teacher Impact

Across my participant interviews, I found that most children were referred through teachers, depending on the agency. Subjects discussed how not only are teachers involved with the referral process but many times they would check in with teachers about progress. As one participant stated, "we need to monitor kids when they are on their meds and take in parent

reports because the way they may be behaving on meds in school may be totally different compared to what is going on at home”. This was common within the participants. What was also common was the belief that teachers were most useful once the social worker had begun their investigation on what was occurring in all of the child’s environments. Participants found that some conversations with teachers and parents that were less helpful in their diagnosis process was when teachers would tell parents that their child has ADHD. Many participants shared that this caused a hindrance as parents became convinced before stepping foot in their clinics and these opinions from the teachers were not diagnoses as teachers are not certified to do the work.

This is also expressed in the literature as it has been discussed that teachers who are asked to take this responsibility or take it on for themselves, are not qualified. Leaving teachers to make referrals leaves no guarantee that referrals or evaluations from teachers are being done correctly or timely (Frauenholtz, Williford, & Mendenhall, 2015).

Therefore, not only are the social workers receiving these evaluations feeling as though teachers are not qualified to be making such diagnoses but based on the literature by Frauenholtz, Williford, and Mendenhall (2015), teachers are also feeling unprepared to identify and intervene with mental health issues. As we have seen in my study, while educators have low mental health literacy they are still expected to make referrals and participate in the evaluation process.

Barriers

The greatest barrier mentioned in the literature by Bauermeister (2003) was around understanding culture and working with a language barrier. Which could ultimately lead to an insufficient diagnosis and treatment plans for these children (Morgan, 2013) (Bauermeister, 2003). Not to mention, when trauma symptoms overlap the possibility of ADHD and clinicians

are attempting to navigate between the two on top of working with language and cultural differences. This puts Latino boys at an even greater risk of misdiagnosis.

As found in the study, one of the greatest barriers agreed upon between the 6 participants was language. A non- Spanish speaking participants expressed her issues around diagnosing and language.

She briefly stated, “yea it’s hard because home visits are so important but what am I or the child getting out of it if I can’t even understand the interaction happening between the family. Many times I just have an older sibling interpret what is occurring and speak for me because we struggle with even getting interpreters in the first place”.

This speaks to not only the language barrier but also how someone who is not a part of the family’s culture is entering their space expected to analyze and diagnose with no idea as to cultural expectations and affect within their language expression.

For Spanish a Spanish speaking participant she found her ability to communicate helpful to her work but with the lack of translators and other Spanish speaking clinicians in her agency she found herself consistently juggling both her own duties and assisting other clinicians- making her stress over time more often.

Between the literature and the results of the study it is evident that language is an important barrier to analyze. Not only does it impact the communication between clinician and family/child it also is a hindrance when clinicians are not only screening for ADHD but in ruling out trauma as well. Now clinicians not only have to account for the language barrier but also use what information they do get from the family to make the best diagnosis.

Best Practices

The study results supported much of the literature around behavior rating scales that seem to be used commonly during the course of the evaluation process. The CDC discussed the importance of using scales and having them completed by parents, teachers, and at times even patients themselves. Every clinician in the study used behavior scales within their method of diagnosing. Though the scales used by the clinicians were not consistent throughout- the CDC does not specify which scale is best. Along with the scales, the general expectation based from the DSM and CDC website is that clinicians gather information from a variety of sources in the client's life including: clinical examination, clinical interviews, and finally an assessment of familial and educational needs. Thus, they do not specify which scale to use, and leave that to the clinician to determine. This can be problematic in terms of validity of specific scales for diverse populations.

The literature discusses the issues within these expectations based on scale results. For instance Flowers and McDougale (2010) discussed that most of these behavior rating scales “have failed to use national samples with significant numbers of ethnic minorities to ascertain that screening questions are in fact detecting equivalent behavioral abnormalities across cultures” (2010). And while they recommend that Terry and Vanderbilt Attention Deficit/ Hyperactivity Disorder scales be used for children of color they discussed that even that is not enough. Again, we miss the exploration for trauma with these scales and the ambiguity within the clinical definitions of “clinical examinations” and “clinical interview” or “assessment of familial and educational needs”, as stated above by the CDC, leaves clinicians with such variety as to how they go about their diagnosing.

The variations in diagnosing were evident amongst the 6 participants in this study. Every clinician used a behavior scale at some point of their evaluation, most at the beginning of their assessment process upon meeting the family. From this point each clinician went in their own direction for exploring a possible diagnosis all influenced by time, language, and protocols of their agency. In the process for evaluating these children there is no requirement to examine for potential trauma even though symptoms of ADHD and trauma can mirror one another. Many of the participants took account for this. Some made sure to get a full biography of the lives of the parents and how that journey has impacted their child. Others did play therapy and watched interactions between the child and other children. Not every participant had the same time to evaluate in their process stuck to a behavior scale completed by 3 adults within the child's life and a one to one clinical assessment with the child. Again, due to the vagueness in the expectations in diagnosing, clinicians are able to do as little or as much as they want when assessing as long as the basic requirements are met.

When the study looked closer into protocols for Latino boys specifically most participants stated that their process was the same. As referenced above by Flowers and McDougale, children of color are not represented in all forms of behavior scales which could also lead us to believe that children of color need their own system of diagnosing or the current system needs to be changed to fit the lives of all of our children. This is where affect of language and issues around trauma like systematic racism, as mentioned by one participant, play a large role in the difference of the diagnostic process.

CONCLUSION

This section discusses study limitations, implications for clinical social work practice, recommendations for future study and closing comments.

Study Limitations

A key limitation of this study was the small number of participants. It is important to emphasize that this was a small scale, qualitative study, and as such, I am not able to make clear generalizations regarding study findings. Another limitation was that all participants identified as women and only one of these women was bi-lingual. There is no male perspective in this research and within the women that spoke only one could speak on the challenges and benefits of being bi-lingual and working within the Latino community. Finally, because this was a time limited study, there was a lack of ample time to fully explore and analyze the data that was gathered, thus limiting some of the findings.

Implications for Social Work Practice

Though the total amount of participants was low important information was gathered that can inform clinical social workers working with school aged Latino boys or adults who were diagnosed with ADHD while in elementary school.

The study highlights that school and clinical social workers need to be aware of inconsistencies relative to racial disparities in the school evaluations that are made for the Latino boys they serve. Most importantly, social workers need to be aware of the issue of consistency in terms of potential disparities that may exist, especially regarding the impact on evaluations of ~~in~~ language barriers that that influence evaluation outcomes, and the potential impact to the evaluation process. Further, social workers need to be aware that attention to cultural variance must be evident in an ADHD evaluation process. Absence of attention to these issues may lead to bias and misdiagnosis, resulting in identifying a diagnosis of ADHD when a childhood PTSD may be the true problem of the child. This is an especially vulnerable area as noted in this study

due to the many different ways that each clinician conducts their evaluations, and the lack of clear protocols designed specifically for working with Latino boys.

School and clinical social workers also need to be aware of what study participants described about the pressures they faced within their agencies to get evaluations done in what was considered a timely manner for their agency. This in itself was an area of inconsistency in that while some agencies require a diagnosis directly following an intake, while others allowed a specific 3 visit time frame. Still other agencies left the window open to the clinician to use his/her own judgement to complete the evaluation process. Social workers need to be aware of this so they are able to see where there may be inconsistency related to time pressures in the diagnostic process. For instance, the evaluation process may not have included home visits, or adequate evaluation time to produce a comprehensive final report. A hidden misdiagnosis is always possible with Latino boys referred for ADHD, for whom missing a trauma based condition is particularly possible, and related to the absence of a comprehensive information collection procedure.

Every participant was able to discuss expanding their evaluations outside of their office spaces that included direct client observations. As noted in the literature, in order to be comprehensive, the evaluation process needs to include reaching out to families within their home setting, talking with school officials, witnessing play therapy and more needs to have occurred prior to writing the final report. One of the greatest consistencies in the research was that evaluators often do not make diagnoses strictly on their interactions with the child. This is important to note in the field as other social workers can apply this to their practice as well. Though every participant had different time restraints and were able to evaluate in different

ways, they did not make evaluations strictly based on their one to one therapeutic experiences with the child.

Last, the issue of having assessments completed by Spanish speaking evaluators is paramount. It is important to note the consistent barrier of language that every participant was able to relate to. Evaluators who were not bi-lingual were able to discuss how affect is lost when clients and their families are attempting to discuss therapeutic concepts with limited English speaking abilities. Also, the few who were provided translators discussed the need of getting a translator that was able to attend every session and even the impact of that third party in sessions. Further, clinicians did speak Spanish struggled with balancing her own work and assisting other clinicians with translation and the impact that had on her own work. It is important to emphasize the necessity for Spanish speaking clinicians to conduct evaluations, and social workers need to check on this when they begin working with the Latino boys that they serve, or the Latino adults who may have been diagnosed while in elementary school, in order to consider if there may be some error in the original evaluation.

Recommendations for Future Research

Recommendations for future study in this area is vast. Of interest would be more surveys of school evaluators to examine the extent to which best practices are used to minimize misdiagnosis between ADHD and childhood PTSD. Surveys across regions and locations would be instructive to determine if regions with higher number of Latino school children follow protocols or have different protocols designed to rule out missing issues of trauma that may be missed. Surveys that examine monitoring practices within school special education departments of the quality of evaluations that are conducted would be of great interest. Also, it may be beneficial to explore agency differences in diagnosing and the requirements being pressed on

clinicians for diagnosing. As this study discussed, because of what clinicians are doing on an individual level in their evaluation decision making, it is important to understand the agency politics and requirements that are instructing clinicians on how it is expected they do the work. Exploring agency dynamics, i.e. private practice versus community based mental health would be an important comparison in what social workers are being expected to do within their occupational settings in terms of evaluation procedures. As many participants explained that they felt pressures from their agencies to get the evaluations done as quickly as possible. Further exploration of evaluation processes across various agencies could be useful to the social work community as a whole. Thus, it would be of interest to survey evaluators about pressures they receive and the extent to which they experience pressures that lead to ‘short cuts’ in the evaluation process, especially with Latino school aged boys. .

Ultimately, this research is valuable in looking at the extent to which protocols for determining the presence of ADHD conditions in Latino, school aged boys are vigorous enough to rule out the presence of childhood PTSD. It is important to discuss the racial disparities in diagnosing and evaluating within this community as it impacts our responsibilities as social workers, allowing us to explore whether we are truly being agents of change or oppression. This research, along with its literature, allows us to recognize some of our deficits in the field of childhood evaluation and provides a base to move in a progressive direction.

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APPENDIX A: Informed Consent Letter and Form



2015-2016

Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

.....
Title of Study: Missing the Mark: Exploring Latino School Aged Boys with the potential of PTSD

Investigator(s): Megan Negron (mnegron@smith.edu)
.....

Introduction

- You are being asked to be in a research study diagnostic protocols for diagnosing school aged Latino boys who have been referred due to issues such as Attention Deficit Hyperactive Disorder or other observed classroom behavioral concerns.
- You were selected as a possible participant because you are licensed to evaluate this population in elementary school and have evaluated Latino school aged boys referred for potential Attention Deficit Disorder or other behavioral concerns in the classroom.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore protocols used to evaluate of Latino school aged boys referred due to possible ADHD who may actually have Childhood Post Traumatic Stress Disorder (PTSD) or other condition with similar symptoms.
- This study is being conducted as a research requirement for my Masters in Social Work (MSW) at Smith College School for Social Work.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to participate in a 40- 45minute interview, either in person or via phone. Interviews will be recorded.

Risks/Discomforts of Being in this Study

- This study is considered low risk. In regards to protecting professional reputation, all information

provided will be kept confidential and fully de-identified, such that there will be no chance to trace interview data with any individuals (see Confidentiality section below).

Benefits of Being in the Study

- The benefit of participation is that you will have an opportunity to describe the procedures you use when evaluating children for behavioral concerns in the classroom and talking about how you avoid misdiagnosis.
- The benefit to the social work/society is that clinicians will learn about protocols used by and issues faced by evaluators when conducting evaluations of school aged Latino boys and how they assure that their results are correct.

Confidentiality

- This study is confidential.
- Your participation will be kept confidential. All transcriptions and analysis will be stored in files in my computer that is password protected. In addition, interview recordings of this study will be kept strictly confidential, with only myself or my thesis advisor having access to this material. Tape recordings will be kept in a locked cabinet. During recording, I will ask that no names or identifying information (such as agency name, children names, or city location) be collected/discussed during taping. Only de-identified, aggregate information will be used in the summary report. All quotes used will be de-identified, and used to illustrate specific categories of results.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may choose to withdraw or decline to answer any question *any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to decline will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 15th, 2016. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Megan Negrón at mnegrón@smith.edu or by telephone at xxx-xxx-xxxx. If you

would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[If using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

APPENDIX B: Recruitment Email

I am emailing you in regards to my thesis that I am currently working on towards my MSW at Smith College. I am looking to interview 12 licensed clinicians who have worked with or are currently working with school aged boys of color, more specifically Latino boys. I want to better understand the evaluation process of diagnosing ADHD and evaluating trauma when working with this specific population.

I would be honored to have the opportunity to interview you in person (preferably) or by phone. As well as any other colleagues you believe may be willing to participate.

Attached below is my informed consent on the research project and the outline for the interview questions. For confidentiality purposes your name, agency, and licenses number will **not** be at all included in any of the research material should you choose to participate.

If you have any clarifying questions or would like to participate I can be reached through email at mnegron@smith.edu or by phone at [xxx-xxx-xxxx](tel:xxx-xxx-xxxx).

Please see the informed consent and interview questions for review in advance.

Thank you.

APPENDIX C: Interview Questions

1. Please describe your procedure for evaluating Latino elementary school aged boys referred to you for ADHD or other behavioral concerns in the classroom.
2. Are you able to conduct all of the steps you describe in your protocol/evaluation procedure?
3. If not, what are barriers?
4. Do you do anything different for Latino boys referred to you for evaluation?
5. Are there any specific steps that you take for non- English speaking families? (i.e. translators, documentation questions translated, etc.)
6. How do you differentiate PTSD symptoms from ADHD symptoms?
7. Evaluation of childhood trauma- how is childhood trauma explored and addressed
8. How do you guard against misdiagnosis?

APPENDIX D: HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 7, 2016

Megan Negrón

Dear Megan,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett'.

Marsha Pruett, PhD
Co-Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor